Comprehensive Medical and Dental Program (CMDP)
Actuarial Memorandum

I. Purpose:

The purpose of this actuarial memorandum is to demonstrate that the Comprehensive Medical and Dental Program (CMDP) capitation rates were developed in compliance with 42 CFR 438.6(c). It is not intended for any other purpose.

This memorandum presents a discussion of the adjustment to the capitation rates effective from January 1, 2009 through December 31, 2009 (CYE09).

II. Base Period Experience:

Since CMDP has a relatively small membership base, multiple years and sources of data were used to increase the statistical credibility. For CYE09 rate development, CMDP's encounter data was found to be credible for all service categories, except pharmacy and hospital inpatient. For all service categories, except pharmacy and hospital inpatient, the base year experience is the 2007 federal fiscal year (FFY07) encounter data for both Prospective and Prior Period Coverage (PPC) CMDP members. CMDP is experiencing submission problems with pharmacy encounters as its Pharmacy Benefit Manager (PBM) is not transmitting/formatting the data correctly. CMDP is working on fixing this issue. CMDP is also experiencing problems with the hospital inpatient encounters. Due to these issues Arizona Health Care Cost Containment System (AHCCCS) did not feel it was appropriate to use the pharmacy or hospital inpatient encounter data as the base data and instead used a blend of the 2007 state fiscal year (SFY07) and the 2008 state fiscal year (SFY08) quarterly financial statements for the pharmacy and hospital inpatient service categories.

Trend rates were calculated from the encounter data and other sources on a unit cost and/or utilization basis by category of service (COS) and a cap was applied to limit the negative and positive trends to a reasonable level. Other data sources include financial data, Center for Medicare and Medicaid Services (CMS) National Health Expenditure Report estimates, fee schedule changes and Global Insight Prospective Hospital Market Basket Inflation Index (GI) information. No adjustment was made other than the ones already described.

CMDP has a relatively small membership base and the members are located statewide. Ideally, the experience should be analyzed by the different rate cells, which are comprised of members with similar risk characteristics; however, segregating the CMDP population into different rate cells would lead to a statistical credibility problem. Therefore, AHCCCS believes that having only two rate cells, Prospective and Prior Period Coverage (PPC), is more actuarially sound than creating more rate cells.

The experience only includes CMDP Medicaid eligible expenses for CMDP Medicaid eligible individuals. In addition, the experience includes reinsurance amounts. PPC rates are reconciled to a maximum of 2% gain or loss. There are no other incentives or risk sharing arrangements.

In general, the base period claim PMPMs are trended to the midpoint of the effective period or July 1, 2009. The next step involves adjusting for program changes, reinsurance offset and third party liability. In the final step, the projected administrative expenses and premium tax are then added to the projected claim PMPMs to obtain the capitation rates. Each step is described in the sections below.

III. Projected Trend Rates

The trend analysis includes encounter experience from October 2004 through September 2007. Where financial data is used (i.e. pharmacy and hospital inpatient service categories) the data is also from October 2004 through September 2007. In addition to using encounter and financial data, AHCCCS used information from CMS National Health Expenditure (NHE) Report estimates, GI information, and changes in AHCCCS' Professional and Outpatient Fee Schedules, Dental Fee Schedule, Transportation Schedule and other sources. AHCCCS developed utilization and unit cost trend estimates using the encounter data. These trends were developed by major category of service (COS), with a cap on the percentage increase and decrease to smooth out unreasonable trends. Once these trends were developed they were analyzed by comparing the results to reports and studies (for example the CMS NHE report). The trend rates used in projecting the claim costs are as follows.

Table I: Prospective and PPC Average Annual Trend Rate

Service Category	Average Annual Trend	
	Prospective	PPC
Hospital Inpatient	0.2%	-2.7%
Physician	4.6%	2.3%
Emergency Services	0.0%	N/A
Pharmacy	7.6%	N/A
Lab, X-ray, & med image	9.0%	N/A
Outpatient Facility	1.8%	N/A
Durable Med Equip	-0.5%	N/A
Dental	5.7%	N/A
Transportation	3.5%	N/A
NF, Home HC	0.0%	N/A
Physical Therapy	0.7%	N/A
Miscellaneous Med Exp	0.0%	2.7%

IV. Projected Gross Claim PMPM

The claim PMPMs were trended to the midpoint of the effective period, which is July 1, 2009. The PMPMs were trended twenty seven months when using FFY07 encounter data. When using the financial data (i.e. for pharmacy and hospital inpatient data) the claim PMPMs were trended for thirty months for SFY07 and for eighteen months for SFY08. For the pharmacy and hospital inpatient service categories the trended financials were a blend of the trended SFY07 financials and the trended SFY08 financials. For all other COS the weight was 100% on the encounters.

V. State Mandates, Court Ordered Programs and Program Changes

Outlier Hospital Reimbursement Rates
This amendment of State law, passed in the 2007 legislative session, changes the methodology for the payment of claims with extraordinary operating costs per day. It stipulates that AHCCCS shall phase in the use of the most recent statewide urban and rural average Medicare or Medicare approved cost-to-charge ratios to qualify and pay extraordinary operating costs starting October 1, 2007. October 1, 2008, begins the second year of the three-year phase-in. Once fully-phased in, those cost-to-charge ratios will be updated annually. In addition, routine maternity charges will be excluded from outlier consideration. Since the base data will not reflect the first year impact, the base data needs to be adjusted by two years of outlier phase-in. The statewide impact to the CMDP program is a savings of approximately $104,000 for CYE09. The statewide impact is a 0.32% decrease.

Hospital Inpatient and Outpatient Rate Freeze
State legislation, signed into law in 2008, mandates that "For rates effective October 1, 2008, through September 30, 2009, the AHCCCS administration shall not increase the inpatient hospital tier per diem rates, inpatient hospital outlier thresholds or aggregate outpatient hospital fee schedule rates above the rates in effect on September 30, 2008..." This produces a savings of approximately $300,000 to the CMDP program.

VI. Projected Net Claim PMPM

The projected gross claim PMPMs were adjusted for the program changes, reinsurance offset, and third party liability to obtain the net claim PMPM. There is no reinsurance offset or third party liability for PPC. For Prospective, the estimated reinsurance offset is $8.15 PMPM and third party liability is $0.09. The projected net claim PMPMs are as follows:

Table II: Projected Net Claim PMPM

Service Category	Projected CYE09 Claim Cost PMPM	
	Prospective	PPC
Hospital Inpatient	$ 37.06	$ 163.22
Physician	$ 49.83	$ 65.65
Emergency Services	$ 7.37	$ -
Pharmacy	$ 36.25	$ -
Lab, X-ray, & med image	$ 9.17	$ -
Outpatient Facility	$ 20.93	$ -
Durable Med Equip	$ 7.53	$ -
Dental	$ 38.79	$ -
Transportation	$ 4.37	$ -
NF, Home HC	$ 1.38	$ -
Physical Therapy	$ 0.00	$ -
Miscellaneous Med Exp	$ -	$ 128.71
Total	$ 212.67	$ 357.58
Less Reinsurance	$ (8.15)	$ -
Less TPL	$ (0.09)	$ -
Net Claim Cost	$ 204.43	$ 357.58

VII. Administrative Expenses

The SFY08 administrative expenses from the SFY08 quarterly financial statements were analyzed and projected to CYE09. In addition, CMDP provided specific information on their projected administration expenses. The administrative PMPMs are as follows.

Table III: Administrative Expenses

Rate Cell	CYE09	% of Capitation
Prospective	$ 29.66	12.42%
PPC	$ 29.66	7.51%

VIII. HIV/AIDS Supplemental Payment

As of October 2008, AHCCCS will no longer reimburse its contractors with a separate HIV/AIDS Supplemental Payment (HASP) for enrollees that have contracted the HIV/AIDS virus. This supplemental payment was originally developed to cover the costs of HIV/AIDS medications and lab testing. For CYE09 AHCCCS reviewed the current HIV/AIDS supplemental payment costs and encounters. The analysis revealed that the HIV/AIDS encounters have been

consistent, without large fluctuations, thus indicating that the data can be rolled into the rates rather than maintaining a supplemental payment. Therefore AHCCCS is removing the HIV/AIDS Supplemental Payment for CYE09 and including the costs for this in the acute component base rates. Statewide impact is budget neutral.

IX. Proposed Capitation Rates and Their Impacts

The proposed capitation rates equal the sum of the projected net claim PMPM (in Section VI) and the projected administrative expenses PMPM (in section VII), divided by one minus the two percent premium tax. Table IV below shows the current and proposed capitation rates and the budget impact from CYE08 to CYE09 using the same membership base.

Table IV: Proposed Capitation Rates and Budget Impact

Rate Cell	Projected CYE09 Member Months	CYE08 Rate	CYE09 Rate	Estimated CYE08 Capitation	Estimated CYE09 Capitation	Dollar Impact	Percentage Impact
Prospective	116,257	$ 250.96	$ 238.86	$ 29,175,810	$ 27,769,103	$ (1,406,707)	-4.8%
PPC	3,917	$ 325.78	$ 395.14	$ 1,275,987	$ 1,547,650	$ 271,663	21.3%
HIV/AIDs	30	$ 1,051.86	$ -	$ 31,556	$ -	$ (31,556)	-100.0%
Total				$ 30,483,352	$ 29,316,752	$ (1,166,600)	-3.8%

X. CMS Rate Setting Checklist

1. Overview of rate setting methodology

AA.1.1: Actuarial certification

Please refer to Section XI.

AA.1.2: Projection of expenditure

Please refer to Section IX.

AA.1.3: Procurement, prior approval and rate setting

This is a sole source contracting method, between AHCCCS and CMDP.

AA.1.5: Risk contract

The contract is an at risk contract, however there are some provisions for reconciliations and reinsurance.

AA.1.6: Limit on payment to other providers

AHCCCS makes no additional payment to providers, except for DSH, GME, and Critical Access Hospitals. GME is paid in accordance with state plan. DSH and Critical Access Hospital payments are paid in accordance with the Waiver Special Terms and Conditions. None of the additional payments to providers were included in the capitation calculation.

AA.1.7: Rate modification

Please refer to Section V.

2. Base Year Utilization and Cost Data

AA.2.0: Base year utilization and cost data

Please refer to Section II.

AA.2.1: Medicaid eligibles under the contract

There are no dual eligibles.

AA.2.2: Spenddown

Not applicable, not covered under this contract.

AA.2.3: State plan services only

The contract between AHCCCS and CMDP specifies that CMDP may cover additional services. Non-covered services were excluded from the base data and not included in the rates.

AA.2.4: Services that can be covered by a capitated entity out of contract savings.

Same as AA.2.3

3. Adjustments to the Base Year Data

AA.3.0 Adjustments to base year data

Please refer to Section II.

AA.3.1 Benefit differences

There are no changes to the covered benefits. Therefore, no adjustment was made.

AA.3.2 Administrative cost allowance calculation

Please refer to Section VII.

AA.3.3 Special populations' adjustment

It is anticipated that the risk characteristics of this population will not change materially from the base period to the effective period of the capitation rates. Therefore, no adjustment was made.

AA.3.4 Eligibility Adjustments

No adjustment was made.

AA.3.5 DSH Payments

No DSH payments were included in the capitation development

AA.3.6 Third party Liability (TPL)

Please refer to Section VI.

AA.3.7 Copayments, coinsurance and deductible in the capitated rates

Not applicable, member cost sharing is not required.

AA.3.8 Graduate Medical Education (GME)

The experience excludes any payments for GME.

AA.3.9 FQHC and RHC reimbursement

The experience excludes any additional payments that FQHCs may receive from the State.

AA.3.10 Medical cost/ trend inflation

Please refer to Section III.

AA.3.11 Utilization adjustment

Other than trend, no specific adjustment was made to utilization. Furthermore, the experience was not broken down into utilization rate and cost per unit.

AA.3.12 Utilization and cost assumptions

Not applicable, since actual experience was used.

AA.3.13 Post-eligibility treatment of income (PETI)

Not applicable, not required to consider PETI.

AA.3.14 Incomplete data adjustment.

The FFY07 encounter data was assumed to be 95% complete; therefore a completion factor was added. The audited financial statements may include outstanding claim liabilities, which were audited and believed to be reasonable by CMDP auditors.

4. Establish Rate Category Groupings

AA.4.0: Establish rate category groupings

Please refer to Section II.

AA.4.1: Age

Please refer to Section II.

AA.4.2: Gender

Please refer to Section II.

AA.4.2: Locality/region

Please refer to Section II.

AA.4.2: Eligibility category

Please refer to Section II.

5. Data Smoothing, Special Populations and Catastrophic Claims

AA.5.0: Data smoothing

Please refer to Section II.

AA.5.1: Special populations and assessment of the data for distortions

Please refer to Section II.

AA.5.2: Cost-neutral data smoothing adjustments

Please refer to Section VI.

AA.5.3: Risk-adjustment

There is no other risk adjustment, except for PPC reconciliation.

6. Stop Loss, Reinsurance, or Risk-Sharing arrangements

AA.6.1: Commercial reinsurance

There is no commercial reinsurance.

AA.6.2: Simple stop loss program

Please refer to Section VI.

AA.6.3: Risk corridor program

There is no risk sharing between AHCCCS and CMDP, except the stop loss program and PPC reconciliation. CMDP assumes all other risks.

7. Incentive Arrangements

There is no incentive arrangement between AHCCCS and CMDP.

XI. Actuarial Certification of the Capitation Rates:

I, Windy J. Marks, am an employee of Arizona Health Care Cost Containment System (AHCCCS). I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established from time-to-time by the Actuarial Standards Board.

The rates were developed using generally accepted actuarial principles and practices and are considered to be actuarially sound. The rates were developed to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and are in accordance with applicable laws and regulations. The rates are appropriate for the Medicaid populations covered and Medicaid services to be furnished under the contract. The rates may not be appropriate for any other purpose. The documentation has been included with this certification. The actuarially sound capitation rates that are associated with this certification are effective for the twelve month period beginning January 1, 2009.

The actuarially sound capitation rates are a projection of future events. It may be expected that actual experience will vary from the values in the rates.

In developing the actuarially sound capitation rates, I have relied upon data and information provided by CMDP and AHCCCS internal database. I have accepted the data without audit and have relied upon the CMDP auditors and other AHCCCS employees for the accuracy of the data.

This actuarial certification has been based on the actuarial methods, considerations, and analyses promulgated from time to time through the Actuarial Standards of Practice by the Actuarial Standards Board.

Windy J Marks 10/05/08

Windy J. Marks Date

Fellow of the Society of Actuaries
Member, American Academy of Actuaries